

FOR DOH USE ONLY (DOH/DTPC Application for Certification)

Program Name: _____ **CR Number:** _____



Anthony A. Williams
Mayor

Government of the District of Columbia

DRUG TREATMENT CHOICE PROGRAM APPLICATION FOR CERTIFICATION

**Department of Health
James A. Buford, Director**

**Addiction Prevention and Recovery Administration
Office of Certification and Regulations
1300 First Street, NE
Washington, DC 20002
(202) 727-9393**

DRUG TREATMENT CHOICE PROGRAM

APPLICATION FOR CERTIFICATION

(Pursuant to Title 29, Chapter 24 of the District of Columbia Municipal Regulations
Reference District of Columbia Choice in Drug Treatment Act of 2000 (DC Law 13-146; D.C. Code § 7-3015))

Please complete **one (1)** application for **each** physical location and return to:
Addiction Prevention and Recovery Administration, 1300 First Street, NE – 3rd Floor, Washington, DC 20002
Attention: Office of Certification and Regulations

[ALL APPLICATIONS MUST BE FILLED OUT ONLINE, THEN PRINT OUT]

(Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> New Applicant | <input type="checkbox"/> Renewal | <input type="checkbox"/> Change in Level of Care |
| <input type="checkbox"/> Change of Program Services | <input type="checkbox"/> Address Change | <input type="checkbox"/> Change in Capacity |

PARENT ORGANIZATION	NAME		
	ADDRESS		
	CITY	STATE	ZIP
	TELEPHONE		WARD (If applicable)
PROGRAM	NAME		
	ADDRESS		
	CITY	STATE	ZIP
	TELEPHONE		WARD
PROGRAM DIRECTOR	NAME		
	TELEPHONE		FAX
	EMAIL		
PRIMARY CONTACT	NAME		TITLE
	TELEPHONE		FAX
	EMAIL		

Program Site Licenses and Certifications

(Attach current copies of certifications, licenses or applications as applicable)

LICENSES, CERTIFICATIONS AND ACCREDITATIONS	YES	NO	PENDING	INCLUDED IN CH. 23 APPLICATION	LICENSE, CERTIFICATE OR PROVIDER #	EXPIRATION DATE (if applicable)
DOH Certification (Title 29 Chapter 23 DCMR)						
DOH Certification Application (Title 29 Chapter 23 DCMR – updated Copy)						
Current accreditation from the Joint Commission On Accreditation of Health Care Organizations (JCAHO) for the treatment of drug abuse, alcohol abuse, or mental illness–						
Current accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)						
Current accreditation from the Council on Accreditation (COA) –						
Currently an approved Medicaid provider as a free standing mental health clinic or substance abuse treatment program						
Currently certified by the Center for Substance Abuse Treatment (CSAT) as an authorized opioid treatment program						
Currently registered with the DEA						
Current Certificate of Occupancy						
Currently licensed under District of Columbia governmental law or regulation (Please specify)_____						
Currently licensed/certified to provide Child Care (Please specify)_____						
Current Certificate of Need (CON), if applicable						
Other (Please specify)_____						
Other (Please specify)_____						
Other (Please specify)_____						

Type of Certification Being Sought:

Check below **all services that apply** at this physical location. State the level of care provided (I, II or III, as specified in Section 2331, Title 29, Chapter 23 of the DCMR.

Type of Certification Being Sought	Level of Care	# of Patients
Certification for Residential Treatment for:	<input type="checkbox"/> Drug Abuse	
	<input type="checkbox"/> Alcohol Abuse	
Certification for Outpatient Treatment for:	<input type="checkbox"/> Drug Abuse	
	<input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> Methadone <input type="checkbox"/> General <input type="checkbox"/> Intensive <input type="checkbox"/> Day Treatment		
Certification for Non-Hospital Detoxification for:	<input type="checkbox"/> Drug Abuse	
	<input type="checkbox"/> Alcohol Abuse	

1. How long has your program been providing the services for which you are requesting certification under the DTCP?

FROM: / /
month day year

TO: / /
month day year

2. Does your program have a system in place to collect outcome measures? ☐ Yes ☐ No

If yes, please attach a description of the system with performance indicators

3. Specify: CLIENT FEE STRUCTURE: ☐ Fixed fee ☐ Sliding fee scale ☐ No fee

4. Is your program able to demonstrate financial viability to meet all necessary and proper capital and operating expenses?

☐ Yes ☐ No

Validate by submitting all of the following documents: **(Check all that apply and attach a copy of each)**

☐ An expense and revenue budget for the current year as approved by the substance abuse treatment provider's governing board.

☐ An expense and revenue budget for the last completed year of operation.

☐ Year-end actual expense and revenue statements for the last completed year of operation.

Other Financial Records (Check all that apply and attach a copy of each)

☐ Notice of Grant Awards.

☐ Contracts

☐ Bank statements

☐ Bank line-of-credit equal to or greater than ninety (90) days of operating expenses.

I certify that the information contained in this application is true and correct to the best of my knowledge. I agree to comply with all applicable statutes and Title 29 Chapter 24 DCMR "Standards For Participation in The Drug Treatment Choice Program".

Name (please print)

Title

Signature of Owner, Officer or Agent

Date

**“CLEAN HANDS ACT”
CERTIFICATION FORM**

TO THE APPLICANT:

PLEASE READ CAREFULLY AND COMPLETELY BEFORE SIGNING.

- A FALSE STATEMENT ON THIS CERTIFICATION REQUIRES THAT THE DEPARTMENT PROCEED IMMEDIATELY TO REVOKE THE LICENSE OR PERMIT FOR WHICH YOU ARE APPLYING, AND FINE YOU \$1,000.00.
- THIS CERTIFICATION IS REQUIRED BY THE ***“CLEAN HANDS ACT OF 1996 ”*** (EFFECTIVE MAY 11, 1996, D.C. LAW 11-118, D.C CODE § 47-2861 et seq.) ***BEFORE RECEIVING A LICENSE OR PERMIT.***

I, _____, certify that _____,
(PRINT NAME CLEARLY) (PROVIDER)

does not owe more than \$100.00 to the District of Columbia Government as a result of:

1. Fines, penalties or interest assessed pursuant to the Litter Control Administration Action of 1985, effective March 25, 1986 (D.C Law 6-100; D.C. Code § 6-2901 et seq.);
2. Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of (1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code § 6-2911 CL et seq.);
3. Fines, penalties or interest assessed pursuant to the Department of Consumer and Regulatory Affairs Civil Infraction Act of 1985, effective October 5, 1986 (D.C Law 6-42; D.C Code § 6-2701 et. seq.); or
4. Past due taxes.

I understand that if I knowingly falsify this Certification, the Department will move to revoke the license or permit for which I am applying, and to fine me \$1,000.00. I further understand that the Department may conduct an investigation to ascertain the veracity of this certification.

I understand that this Certification is now required as documentation to accompany my application for a license or permit, and that by completing this Certification, I am not guaranteed that my license or permit will be approved.

SIGNATURE OF APPLICANT

TITLE

DATE

FOR DOH USE ONLY (DOH/DTPC Application for Certification)

Program Name: _____ **CR Number:** _____